MAXIMUS Federal Services, Inc.
4000 IH 35 South, (8th Floor) 850Q
Austin, TX 78704
Tel: 512-800-3515 ◆ Fax: 1-877-380-6702

Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: October 2, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Occupational therapy at the frequency of two sessions per week for six weeks (97110, 97140, 97530).

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

M.D., Board Certified in Physical Medicine and Rehabilitation.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☒**Upheld** **(Agree)**

☐Overturned (Disagree)

☐Partially Overturned (Agree in part/Disagree in part)

The requested occupational therapy at the frequency of two sessions per week for six weeks (xxxx) is not medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who reported a work-related injury on xx/xx/xx. The patient has a history positive for right wrist pain. The patient has participated in approximately eight sessions of physical therapy. Magnetic resonance imaging (MRI) of the right wrist without contrast dated 12/4/14 revealed no gross evidence of triangular fibrocartilage tear or intrinsic ligament injury. A physical therapy evaluation dated 6/24/15 noted the patient complained of decreased grip strength. She also complained that she has pain while working without brace use. She rated her

pain at 7/10. Physical examination revealed triangular fibrocartilage complex (TFCC) and scaphoid were tender to palpation with a negative grind test. The patient had a positive Finkelstein's test and a range of motion of the wrist flexion of 40 degrees. The patient's Jamar grip test on setting number two was 25 as compared to 50 on the opposite side. The plan of care was for the patient to participate in therapy two times per week for four weeks.

The URA indicates that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. The denial letter dated 8/14/15 indicates that the patient received eight physical therapy sessions, however there was no documented progress with prior history and the MRI ruled out treatable pathology.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

Per Official Disability Guidelines (ODG), the recommended amount of occupational therapy for wrist pain is nine sessions. The ODG also recommend an initial trial of therapy and with documentation of functional improvement additional sessions may be warranted. In this case, the patient has previously participated in eight sessions of physical therapy for the complaints of right wrist pain. However, there were no physical therapy notes provided for review to evidence measurable functional improvement with use of therapy to support ongoing therapy. Furthermore, the request for an additional 12 sessions of therapy would exceed guideline recommendations and there are no noted exceptional factors to support exceeding the guidelines. Despite the patient having functional limitations in regards to range of motion and grip strength, due to the lack of documentation evidencing functional improvement with use of previous therapy and the lack of noted exceptional factors to support exceeding the guidelines, the medical necessity has not been substantiated for the requested services. In accordance with the above, I have determined that the requested occupational therapy at the frequency of two sessions per week for six weeks xxxxxx is not medically necessary for treatment of the patient's medical condition.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☐ **MEDICAL JUDGMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**